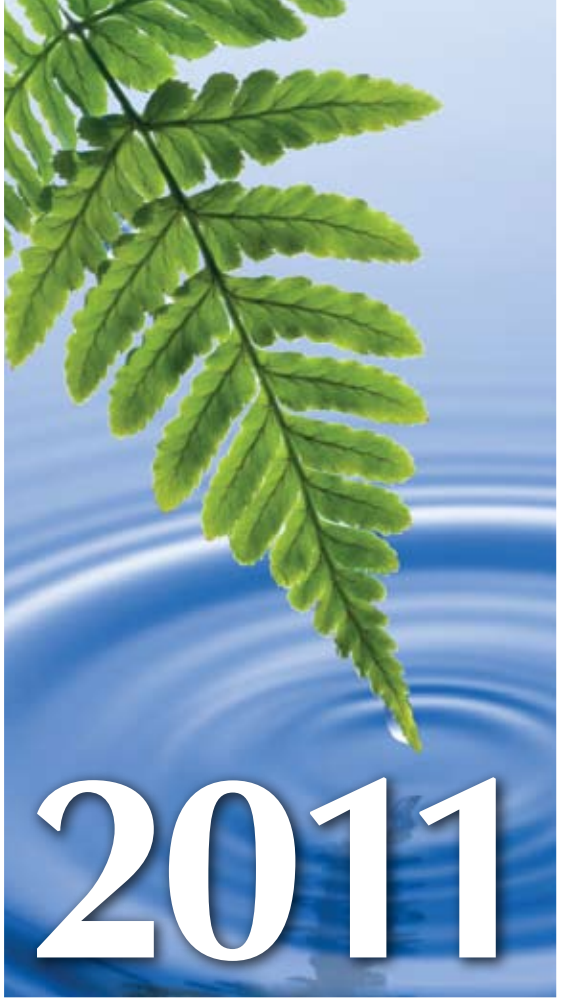
Plan Year 2011



2011 Employee Reimbursement Accounts Program (ERA)

An Optional Tax-free Benefit Plan

OPEN ENROLLMENT
OCTOBER 4 - NOVEMBER 12, 2010

Current participants must re-enroll to continue Reimbursement Account(s) in 2011.

Eligible new employees have 30 days following date of hire to enroll.

Employee Resource Directory

FRINGE BENEFITS MANAGEMENT COMPANY (FBMC)

Reimbursement Requests:
P.O. Box 1800
Tallahassee, FL 32302-1800
FAX: 1-888-326-2658

FBMC Customer Care:
Toll-Free Phone: **1-800-342-8017**
Monday – Friday, 6 a.m. – 9 p.m. CT
http://www.myFBMC.com

Interactive Benefits:
1-800-865-FBMC (3262)
http://www.myFBMC.com
Your personal Employee Reimbursement Account (ERA) and Commuter Benefits account information, available 24/7

myFBMC Card® Visa® Card

Lost or Stolen
24 hours a day
1-888-462-1909

Dispute Line
FBMC Customer Care Center
Mon - Fri, 6 a.m. - 9 p.m. CT
1-800-342-8017

Activation
http://www.myFBMC.com
1-888-514-6845

EMPLOYEE TRUST FUNDS

Mailing Address:
P.O. Box 7931
Madison, WI 53707-7931

ETF Website:
http://etf.wi.gov
Another way to link to ERA program information, forms and access to your personal account information. Click on the "Members" tab at the top of the page, then select "Employee Reimbursement Account Program" from the menu.

OPEN ENROLLMENT (October 4 - November 12, 2010)

Internet enrollment:
http://www.myFBMC.com

Telephone enrollment:
1-800-847-8253
The enrollment line will close at 9:00 p.m. CST on November 12.

Enrollment Help Line:
1-888-909-3262 (toll-free), or (608) 592-2010
Available only from October 4 though November 12, 2010. Call if you're having trouble logging on or enrolling online or via phone. (This is **not** an enrollment line.)

Need a print copy?
Send a request to ERABenefitsGuide@fbmc.com or call toll-free 1-866-440-7149.
Keep this booklet for your reference throughout the plan year.

Employee Reimbursement Accounts

Program Summary

What's New	Beginning Jan. 1, 2011, most over-the-counter (OTC) drugs and medicines will no longer be eligible for reimbursement without a prescription from your physician. Visit **www.myFBMC.com** for more information about OTC eligibility. As of the printing date of this booklet, the Wisconsin tax code has not been updated to match the federal tax exclusion for medical expenses for non-tax-dependent adult children as provided in the Patient Protection and Affordable Care Act (PPACA). Therefore, the ERA plan must follow federal definition of eligible dependent that was in effect prior to the passage of PPACA. This means that you may not submit claims for your non-tax-dependents.
Employee Reimbursement Accounts Program	The Employee Reimbursement Accounts (ERA) Program is a benefit that allows you to set aside money for eligible medical or dependent day care expenses before taxes are deducted from your paycheck. The ERA program saves you money by reducing your Federal, State and Social Security taxes. A Medical ERA can be used for eligible medical expenses incurred by you and your dependents that are not covered by insurance. These include deductibles, copays and certain out-of-pocket expenses such as dental, vision, prescriptions and certain OTC items. See Page 14. A Dependent Care Account can be used to pay for eligible dependent care expenses incurred so that you and your spouse (if married) can work, actively look for work, or so that your spouse can attend school full time. See Page 20.
Eligibility	Most full-time or part-time classified and unclassified state and University employees are eligible to participate. Employees who are classified as fellows, scholars, and research assistants in the University of Wisconsin System, limited term employees (LTEs), student hourlies, per diems and other temporary employees may not participate. **Note:** Federal tax law does not allow participation by an employee's domestic partner or their partner's children unless they meet the IRS definition of dependent.
Enrollment	**Open Enrollment: October 4 - November 12, 2010.** Internet enrollment: **http://www.myFBMC.com** Telephone enrollment: **1-800-847-8253** The enrollment line will close at 9:00 p.m. CST on November 12. **Newly Hired/Eligible**–Electronic enrollment is not available outside of the open enrollment period. A paper application must be completed and submitted to your department's payroll/benefits representative within 30 days of your hire/eligibility date.
Plan Year	The plan year is the period during which eligible expenses must be incurred to be eligible for reimbursement, regardless of when the services are billed or paid. **Plan Year** January 1 – December 31, 2011 **Grace Period*** January 1 – March 15, 2012 **Reimbursement Filing Deadline** April 15, 2012 **Newly Hired/Eligible**–If you enroll within 30 days following your hire date or the date of your Change in Status qualifying event, your period of coverage starts on the first day of the month that begins on or after the date your enrollment form is received by your Payroll/Benefits Office or the date your Change in Status form is received by the FBMC Wisconsin office. Only eligible expenses incurred on or after this effective date are reimbursable. *Services received during the grace period may be reimbursed from funds remaining from the 2011 plan year.
Plan Carefully	Your election is irrevocable after coverage has started, unless you have a qualifying Change in Status event. Only expenses for services provided to you or your qualified dependents during the plan year (including the grace period) are reimbursable. Any unused amounts from the plan year that are not used for expenses incurred by March 15 of the following year will be forfeited to the State. Funds cannot be returned to you.

TABLE OF CONTENTS

Employee Reimbursement Accounts Program (ERA)

An Optional Tax-free Benefit Plan for Eligible Employees

General Information

What is the ERA Program?

The Employee Reimbursement Accounts (ERA) Program is an optional benefit established for eligible state employees. Employee Reimbursement Accounts, also referred to as "Flexible Spending Accounts," are authorized under Sections 125, 105, and 129 of the Internal Revenue Code and Wis. Stats. §40.85 – §40.875. The ERA program allows you to pay for eligible expenses from your pre-tax income rather than your after-tax income.

The Employee Reimbursement Accounts (ERA) program has three different parts:

- A tax-free Medical Expense Reimbursement Account that covers eligible expenses not reimbursed by any medical, dental, or vision care plan you or your dependents may have.
- A tax-free Dependent Care Reimbursement Account that covers eligible dependent care expenses incurred so that you and your spouse (if married) can work, actively look for work, or so that your spouse can attend school full time. **This account is NOT for medical expenses incurred by your dependents.**
- Automatic Premium Conversion, the automatic pre-tax treatment of your payroll deducted premiums for state group health and group life insurance (**excluding** spouse and dependent life insurance costs), EPIC dental and excess medical insurance, VSP vision plan and DentalBlue dental plan.

Here's how the ERA program could increase your spendable income by saving taxes:

ERA Savings Example*

(With ERA)		*(Without ERA)*
$39,000.00	Annual Gross Income	$39,000.00
- 5,000.00	ERA Deposit for Recurring Expenses	- 0
$34,000.00	Taxable Gross Income	$39,000.00
- 6,863.50	Federal, Social Security Taxes	-7,996.00
$27,136.50	Annual Net Income	$31,004.00
- 0	Cost of Recurring Expenses	-5,000.00
$27,136.50	Spendable Income	$26.004.00

By using an ERA to pay for anticipated recurring expenses, you convert the money you save in taxes to additional spendable income. That's a potential annual savings of

$1,132.50!

* Figures assume a 12-month plan year, federal withholding married, filing jointly (10% on first $16,750, 15% on remaining balance) and 7.65% Social Security taxes. Individual tax rates may vary. State of Wisconsin income tax has not been included in these calculations.

Beginning January 1, 2011, certain OTC drugs and medicines will no longer be eligible for reimbursement without a prescription from your physician.

Be sure to visit www.myFBMC.com for regular updates about OTC eligibility.

Here's how the ERA program works

- Determine how much money you need to set aside. Plan carefully. If you have unused dollars at the end of the plan year, including through the grace period of March 15, 2011, they will be forfeited. The worksheet on Page 30 can help you plan your account contribution.
- The amount you set aside is deducted from your pay on a pre-tax basis in equal amounts throughout the year. For example, if you decided to contribute $910 to your Medical Expense ERA and you are paid 26 times per year, you would have $35 deducted from each paycheck and credited to your Medical Expense ERA.
- When you have eligible expenses, use your myFBMC Card® to pay for them or submit a claim for reimbursement for expenses that you paid out-of-pocket. Include appropriate documentation to support your claim, such as an itemized bill or receipt, or an Explanation of Benefits (EOB) from your insurance company.
- FBMC will promptly process your claim. Claims are processed within five business days after receipt by FBMC and eligible expenses will be reimbursed via check, or directly deposited into your bank account if you choose Rapid Refund.

All of your ERA contributions (including premiums deducted through Automatic Premium Conversion) are taken out of your paycheck before federal and state income, and Social Security taxes are calculated on your remaining salary. You keep more money in your pocket because you pay less in taxes!

General Information

Who is eligible to enroll?

- Most full-time or part-time classified and unclassified state and university employees are eligible to participate.
- Employees who are classified as fellows, scholars, and research assistants in the University of Wisconsin System, limited term employees (LTEs), student hourlies, per diems and other temporary employees may not participate.

How much should I contribute?

- You can contribute up to $5,000 in a Dependent Care Reimbursement Account and $7,500 in a Medical Expense Reimbursement Account. The minimum contribution for both accounts is $100.
- Plan carefully before you enroll. Funds remaining in your account(s) at the end of the plan year and your grace period, after all eligible expenses have been reimbursed, will be forfeited to the State of Wisconsin.
- Carefully review your **It's Your Choice** booklet to help determine your medical expenses. Also review any other health, dental, or vision coverage you may have that may affect your healthcare costs.
- Use the ERA worksheets provided on Page 30 of this booklet to help you calculate the amount you expect to pay during the plan year for eligible dependent care and/or uninsured out-of-pocket medical expenses. (Refer to the individual reimbursement account descriptions on Pages 14-18 in this booklet for information specific to each type of account.)
- Be sure the amount you set aside is a realistic amount. Keep in mind that you have to make contributions to your reimbursement account and also pay for expenses out-of-pocket before a reimbursement check arrives.

What expenses are eligible for reimbursement?

Only expenses for services that you **receive** during your period of coverage in the 2011 Plan Year are eligible for reimbursement, regardless of when you were billed or when you pay for them. More details about eligible medical and dependent care expenses may be found on Pages 14-22.

Can my insurance premiums be reimbursed?

No, IRS regulations prohibit the reimbursement of any insurance premiums through a medical expense reimbursement account. However, premium payments for state group health, life, vision, dental and EPIC excess medical coverage are automatically deducted from your paycheck on a pre-tax basis, unless you have filed a Premium Conversion Waiver Form. See Page 13 for more information about Automatic Premium Conversion.

Will the full amount of each claim be reimbursed?

Eligible claims for medical expenses will be paid up to the annual amount you've elected to contribute to your Medical Expense ERA, even though your total annual deductions have not been taken from your paycheck.

Dependent care expenses will be paid up to your current balance. If you file a claim for more than your current dependent care balance, the claim will be paid up to the balance in your account and the remainder will be held until additional contributions have been added to your account.

When does my period of coverage start?

- If you enroll during the Open Enrollment period, your period of coverage begins January 1, 2011.
- If you enroll within 30 days following your hire date or the date of your Change in Status qualifying event, your period of coverage starts on the first day of the month that begins on or after the date your enrollment form is received by your Payroll/Benefits Office or the date your Change in Status form is received by FBMC's Wisconsin Office (see Page 24). Only eligible expenses incurred on or after this effective date are reimbursable. See Page 24 for more information about Change in Status effective dates.

Your first payroll deduction will be on the first available paycheck. The date of the first deduction will depend on the date your enrollment form is received by your Payroll/Benefits Office, as well as payroll cut-off dates. The first deduction may occur before or after the coverage start date.

EXAMPLE:
Your employment start date is March 15, 2011. You have 30 days after that date to enroll in the program. If your employer receives your properly completed and signed enrollment form on or before April 1, your coverage will start on April 1. If your enrollment form is received between April 2 and April 14, your coverage will start on May 1.

General Information

When does my period of coverage end?

- If you remain employed to the end of the plan year (December 31, 2011), you can incur medical and/or dependent care expenses through March 15, 2012, and be reimbursed from 2011 contributions.

Medical Expense Account

- If you terminate employment or cease to be an eligible employee prior to the end of the plan year and do not arrange to continue your coverage, your coverage ends at the end of the month in which your last ERA payroll deduction was taken. Expenses for services provided to you after this date are not reimbursable.

Examples:

1. An employee whose last bi-weekly paycheck is dated April 13 will have ERA coverage end as of April 30.
2. An employee whose last monthly paycheck is dated May 1 will have ERA coverage end as of May 31.

Dependent Care Account

- If you terminate employment or cease to be an eligible employee prior to the end of the plan year, you cannot continue dependent care contributions. You can continue to request reimbursement for eligible expenses from your Dependent Care Reimbursement Account until you exhaust your account balance or March 15, 2012, whichever comes first, even if you have not contributed the full annual amount for which you enrolled.

What happens if I don't spend all of my money?

IRS regulations stipulate that any amount left in your account at the end of a plan year after all submitted reimbursement requests have been processed will be forfeited to the State of Wisconsin. Funds cannot be returned to you.

Can I use money from one account to pay for expenses from another account?

No, funds deposited in a dependent care account cannot be used to reimburse medical expenses (and vice versa).

Can I continue coverage if I terminate employment or take a leave of absence?

Your participation in the ERA program may cease during a plan year if you terminate employment, transfer to an ineligible position or go on an unpaid leave of absence, unless you make arrangements to continue your coverage.

There are several ways for you to continue your reimbursement account(s) for the remainder of the plan year.

- You can contribute the remainder of your annual election amount via a **tax-free** lump sum contribution taken from your last regular paycheck(s). When you have contributed your full annual election amount to your account(s), you can receive reimbursement for eligible expenses until your full annual amount has been reimbursed or the plan year ends (including the grace period), whichever occurs first.
- You can contribute with **after-tax** payments to your account (Medical Expense Reimbursement Accounts only).
- In some cases you may also change your election amount by filing a Change in Status Form. See Pages 24-26 for more information about qualified Changes In Status events.

Contact your Payroll/Benefits Office for more information about your options and the required procedures for continuation.

Appeal Process

If you have a claim denied in full or in part, or if you have a Change In Status request denied, you have the right to appeal the decision by sending a written request for review to the address below within 30 days of the denial. Your written request must state why you think your request should not have been denied. Your letter must include the name of your employer, the date of the services for which benefits were denied (if applicable), a copy of the claim or request, any denial letter you received and any additional documents, information or comments you think may have a bearing on your appeal.

Upon receipt of your written request, your appeal will be reviewed. You will normally be notified of the results of this review within 30 days from receipt of your written request. In unusual cases, as when review of your appeal requires additional documentation, the review may take longer than 30 days. If your appeal is approved, additional processing time is required to modify your benefit elections or process your claim.

PLEASE NOTE: Appeals are approved only if the extenuating circumstances and supporting documentation are within IRS regulations governing the plan.

Fringe Benefits Management Company (FBMC)
Appeals Committee
P.O. Box 1878
Tallahassee, FL 32302-1878
1-800-342-8017

Enrollment Information

When can I enroll?

Open Enrollment October 4 – November 12
Current employees must enroll in the Medical Expense Reimbursement Account and/or the Dependent Care Reimbursement Account for the 2011 Plan Year during the Open Enrollment period. (You do not need to re-enroll for Automatic Premium Conversion. Your participation will continue automatically.)

How do I enroll during open enrollment?

There are two fast and easy ways to enroll:

- **Telephone** – Call toll-free (1-800-847-8253), then follow the voice prompts.
- **Internet** – Log on to **http://www.myFBMC.com** or go to the Employee Trust Funds internet site.

Call or log on anytime between October 4 and November 12, 2010. The enrollment line closes at 9 p.m. CST on November 12, 2010. Be sure to write down your Confirmation Number before ending your enrollment session over the telephone or on the Internet.

Important Information About Your User ID and Personal Identification Number (PIN)?

FBMC has implemented a unique 16-digit employee account number to identify your account. This number will be used in all communication with you about your ERA account and you may use it on your FBMC claim forms in lieu of your Social Security number (SSN). This number will also serve as your User ID on the FBMC Interactive Voice Response (IVR) telephone system. You may obtain your FBMC employee account number via the FBMC website, the FBMC IVR phone line or by calling FBMC Customer Care.

Using myFBMC.com:
You may access your FBMC Account Number, as well as other ERA account information, via the Internet at **www.myFBMC.com**. If you have used the site since January 19, 2008, and are already registered, just enter your e-mail address and password under the "Registered Users" heading.

If you have not registered, select the "Click Here to Register a New Account" link under the "New User" heading. You will be asked to enter your name, zip code and e-mail address. You will also be asked to supply your FBMC Account Number, Employee ID or SSN, as well as an eight-character password. If you already know your 16-digit FBMC Account Number, you may use that. If you don't know your FBMC Account Number, you may enter your SSN. If you prefer, you may call FBMC Customer Care at 1-800-342-8017 to obtain your 16-digit FBMC Account Number.

After you have submitted the required information, a confirmation will be sent to the e-mail address you provided so that FBMC can verify that it is valid. This confirmation e-mail will contain a verification link that you must click in order to complete the registration process.

After this one-time registration has been completed, you will only need your e-mail address and password to access your account information at **www.myFBMC.com** or to enroll on-line during the open enrollment period.

Using the Interactive Benefits phone line:
To access your account information, including your FBMC Account Number, via the Interactive Benefits IVR phone line, call **1-800-865-FBMC (3262)** and follow the prompts. To log on initially, use your SSN as your User ID and your four-digit password, the same password you used if you enrolled last year via the phone system. If you have not used the FBMC Interactive Benefits phone line before, your PIN is the last four digits of your SSN. You will be required to change the PIN to one of your choosing. **(Note: The IVR phone system will only accept a 4-digit PIN. If you use both the IVR system and the FBMC internet site to access your ERA account information, you will have two different passwords.)**

Enrollment Information

On the IVR system, a recording of your FBMC Account Number will be a menu item. **Please be sure to write it down for future reference.** This account number may be used as your User ID whenever you access your personal account information or enroll via the IVR phone system.

If you forget your FBMC Account Number or Password:
If you forget or lose your FBMC Account Number, simply log back in to the FBMC website. The number is listed on the first menu page. If you use the Interactive Benefits IVR phone system, log on using your SSN and PIN. Your FBMC Account Number will be noted as a menu item on the IVR system.

If you forget your internet password, simply click on the "Forget Your Password?" link under the login box. An e-mail will be sent to your registered e-mail address that will provide instructions on how to choose a new password. If you use the IVR phone system, call or send an e-mail to FBMC Customer Care to have your password reset.

If you have any questions, please contact FBMC Customer Care at 1-800-342-8017, or click the Contact link on the **www.myFBMC.com** homepage.

Can I change my election during open enrollment?

Yes, you can change your election at any time during the open enrollment period. Simply use the Internet or telephone enrollment line at any time during the open enrollment period to make the change. **Only the last election that you made will be saved.** Be sure to record and save your new confirmation number every time you change your election. If you enroll via the Internet, be sure to carefully review the amount entered and print your confirmation page.

IMPORTANT: If you enrolled for both a Medical Expense Account and a Dependent Care Account, but wish to change the election amount for only one account, please remember to enter the amount you wish to contribute to both, not just the one account you are changing. If you only enter contribution amounts for one account, only that information will be saved and you will be enrolled in only one ERA account for the 2011 Plan Year.

Can I change my election after open enrollment?

If you wish to change or cancel your election after November 12 but before the plan year starts, you may mark your desired change on your Confirmation Notice (either the one that you printed at the time you enrolled online, or the confirmation sent to you by FBMC) and send it to FBMC. If you have misplaced your Confirmation Notice, complete a paper enrollment form with your desired election amount(s). Be sure to include a notation that it is a "supersede" for the 2011 plan year.

Requests for late enrollment after November 12 may be made by writing an enrollment appeal request letter outlining the circumstances that prevented you from enrolling during the open enrollment period. Send the letter, along with a completed enrollment form, to FBMC.

All requests for enrollment changes or late enrollments may be mailed to the Wisconsin Appeals Committee at FBMC, P.O. Box 1878, Tallahassee, FL 32302, or faxed to the Wisconsin Client Services Specialist, Client Services (1-850-425-6220). In all cases you will be notified by FBMC when your request is approved or denied.

Can I change my election after the plan year begins?

Enrollment elections cannot be changed after the plan year begins unless there is a qualifying change in status event that affects your eligibility to participate in the benefit.

Benefit election changes are allowed only if the requested change is on account of and corresponds to the status change event and must be approved by FBMC before it can take effect. **See Pages 24-26 for more information about change in status events and how to request a change.**

Can I enroll after the Open Enrollment period?

Enrollment after the annual open enrollment period is not permitted unless you are a newly-hired employee or experience a qualifying change in status event.

Enrollment Information

Enrollment for newly hired employees

You may enroll in the ERA program by submitting an enrollment form within 30 days following your hire date.

Step 1 – Determine the amount you wish to contribute for the remainder of the plan year following your effective date of coverage. Your department's Payroll/Benefits Office will assist you in determining the number of paychecks remaining in the year.

Step 2 – Complete a paper ERA Enrollment Form available from your Payroll/Benefits Office or ETF website. (The Internet and phone enrollments are **not** available after the Annual Enrollment period.)

Step 3 – Return your completed enrollment form to your Payroll/Benefits Office, **not** to FBMC.

Enrollment for employees who experience a Change in Status

You may enroll in the ERA program by submitting a Change in Status Form within 30 days after you experience a Change in Status event such as marriage, birth, or adoption. **See Pages 24-26 for more information on valid Change in Status events and for instructions on how to enroll via a Change in Status form.**

When will my coverage start if I enroll mid-plan year?

If you enroll within 30 days following your hire date or the date of your change in status qualifying event, your coverage will start on the first day of the month that begins on or after the date your approved Change in Status Form is received by FBMC's Wisconsin Office or your enrollment form is received by your employer. Only eligible expenses for services provided to you on or after this effective date are reimbursable.

Your first payroll deduction will be on the first available paycheck. The date of the first deduction will depend on the date your enrollment form is received by your Payroll/Benefits Office (new hires) or your Change in Status Form is received by FBMC and the dates of your Change in Status events, as well as payroll cut-off dates. The first deduction may occur before or after the coverage start date.

EXAMPLE:

Your employment start date or Change in Status event is March 15, 2011. You have 30 days after that date to enroll in the program. If your employer receives your properly completed and signed enrollment form, or FBMC's Wisconsin Office receives a Change in Status Form, on or before April 1, **and if the event has occurred on or before the first of the month**, your coverage will start on April 1. If your form is received or your Change in Status event is between April 2 and April 14, your coverage will start on May 1.

ERA Enrollment Guide

Internet Enrollment: http://www.myFBMC.com
Telephone Enrollment: 1-800-847-8253

THIS IS NOT AN ENROLLMENT FORM. Use this guide to make your enrollment via Internet or telephone fast and easy. Call the Wisconsin help line listed below if you need a paper form.

USER ID

FBMC has implemented a 16-digit account number. This number will serve as your User ID in lieu of your Social Security Number (SSN) when enrolling via the IVR phone system. **See Page 8 for information about how to obtain your FBMC Account Number.**

PASSWORD

See Page 8 for information about your password.

WORK LOCATION NUMBER (Refer to the list on next page) ☐☐☐

Your work location may not be properly identified if you are a new employee or have recently changed jobs. Call the Wisconsin Enrollment Help Line if your work location is not properly identified.

NUMBER OF PAYCHECKS ☐☐

Employees paid bi-weekly will receive 26 paychecks in 2011. Employees paid monthly may receive 12 paychecks if they have a full-year appointment. Those with less than a full-year appointment, i.e. 6 months, 9 months, 10 months etc., should use the appropriate number.

WORK PHONE NUMBER ☐☐☐-☐☐☐-☐☐☐☐

E-MAIL ADDRESS

This information is used solely for program administration. In no event will it be sold or used for any other purposes.

ERA annual deduction amounts: (include decimal for Internet) $ ☐☐☐☐.☐☐

Medical Expense Annual Amount (Minimum = $100; Maximum = $7,500) $ ☐☐☐☐.☐☐

Dependent Care Annual Amount (Minimum = $100; Maximum = see below)

TAX FILING STATUS (DEPENDENT CARE ACCOUNTS ONLY)

- ☐ **MARRIED, FILING SEPARATELY ($2,500 MAXIMUM)**
- ☐ **MARRIED, FILING JOINTLY ($5,000 MAXIMUM)**
- ☐ **SINGLE, HEAD OF HOUSEHOLD ($5,000 MAXIMUM)**

Write your Confirmation Number here: (Keep for future reference)

IF YOU HANG UP OR QUIT BEFORE YOU RECEIVE A CONFIRMATION NUMBER, YOUR BENEFIT SELECTIONS HAVE NOT BEEN SAVED AND YOU ARE NOT ENROLLED.

IF YOU ENROLL ONLINE, PLEASE PRINT THE SUMMARY PAGE FOR YOUR RECORDS.

You can change your election through the Internet or telephone system at any time during Open Enrollment. See Page 9 for specific instructions. No changes can be made after the plan year begins unless you experience a qualifying change in status event. See Page 24-26 for more information about change in status events.

TROUBLE ENROLLING? CALL THE WISCONSIN HELP LINE TOLL-FREE AT 1-888-909-3262.

Work Location Numbers

505 Administration
432 Aging and Long Term Care Board
115 Agriculture, Trade and Consumer Protection
215 Arts Board
437 Children and Families
625 Circuit Courts
143 Commerce
410 Corrections
660 Court of Appeals
438 Developmental Disabilities Board
475 District Attorneys
225 Educational Communications Board
425 Employment Relations Commission (WERC)
515 Employee Trust Funds
525 Executive Office
144 Financial Institutions
511 Government Accountability Board
435 Health Services
235 Higher Educational Aids Board
499 HIRSP Authority
245 Historical Society
145 Insurance Commission
536 Investment Board
665 Judicial Commission
670 Judicial Council
455 Justice
765 Legislature
- Assembly
- Sergeant at Arms
- Legislative Council
- Legislative Fiscal Bureau
- Legislative Reference Bureau
- Senate
- Revisor of Statutes
- Legislative Technology Services Bureau

770 Legislative Audit Bureau
360 Lower Wisconsin Riverway Board
540 Lieutenant Governor's Office
465 Military Affairs
370 Natural Resources
545 Office of State Employment Relations (OSER)
550 Public Defender
255 Public Instruction
507 Public Lands, Board of Commissions
155 Public Service Commission
165 Regulation and Licensing
566 Revenue
575 Secretary of State
190 State Fair Park Board
585 State Treasurer
680 Supreme Court
380 Tourism
395 Transportation
495 UW Hospital and Clinics
285 University of Wisconsin
- UW - Eau Claire
- UW - LaCrosse
- UW - Stout
- UW - Oshkosh
- UW - Platteville
- UW - River Falls
- UW - Stevens Point
- UW - Superior
- UW - Whitewater
- UW - Madison
- UW - Milwaukee
- UW - Green Bay
- UW - Parkside
- UW - Colleges
- UW - Extension
- UW - System Admin.

485 Veteran's Affairs
440 Wisconsin Health and Educational Facilities Authority (WHEFA)
490 Wisconsin Housing and Economic Development Authority (WHEDA)
292 Wisconsin Technical College System Board
100 WISCRAFT
445 Workforce Development

Automatic Premium Conversion

Which premiums may be taken on a pre-tax basis?

Premium Conversion allows the following premiums to be deducted from your salary on a pre-tax basis:

- State group health insurance
- State group life insurance
- EPIC dental and excess medical insurance
- VSP vision benefit
- DentalBlue dental insurance

IMPORTANT: The premiums that you pay for other coverage (for example: other medical, dental, life, income continuation or long-term care insurance) are **not** affected by this plan.

IRS regulations require that employer-provided group term life insurance coverage in excess of $50,000 results in a tax liability. This liability is offset by the portion of life insurance premiums you pay. Any liability you incur will appear on your annual wage and tax statement (W-2 Form) that you receive each January.

Do I need to re-enroll every year?

No, you do not need to re-enroll for Automatic Premium Conversion. Your participation will continue automatically.

Are there any restrictions for premium conversion participation?

Internal Revenue Code regulations governing premium conversion restrict changes that can be made to your benefits during the plan year. You may not make changes or cancel your participation during the same year in any of the benefits for which premiums are being taken on a pre-tax basis unless your decision to do so is a result of a qualifying change in status event. Keep in mind that the benefit plan may also have other restrictions on allowable changes during the plan year, in addition to those required under premium conversion.

Note: If you have insurance coverage that includes a domestic partner or other individual who cannot be claimed as a dependent on your income tax returns, the fair market value (FMV) of benefits covering such an individual will be calculated and added to your earnings as taxable income.

What if I don't want to participate in automatic premium conversion?

If you wish to waive your participation in premium conversion, fill out an Automatic Premium Conversion Waiver/Revocation of Waiver Form (ET-2340) and return it to your Payroll/Benefits Office. You can obtain a Waiver form from your Payroll/Benefits Office, or by going to the ETF Internet site.

When will the waiver be effective?

- If you file a waiver within 30 days after the date you are first eligible to participate in the ERA program, the date you are first eligible for insurance that is affected by premium conversion, or the date you experience a qualifying change in status event, the waiver will be effective on the first of the month following the processing of your form.
- If you file the waiver at any other time, it will become effective on January 1 of the following plan year.

Once you have filed a waiver it will remain in effect for future plan years, unless you file an Automatic Premium Conversion Waiver/Revocation of Waiver Form (ET-2340) with your Payroll/Benefits Office.

Medical Expense Reimbursement Account

This account allows you to use tax-free money to pay for uninsured medical expenses incurred by you, your spouse and your dependents.* All expenses must be for services **provided** during the plan year or during your period of coverage.

***Note:** Federal tax law does not allow an individual to be covered under a Medical Expense Account unless they are a qualified dependent as described below. Therefore, you cannot be reimbursed for the expenses of anyone who does not meet this definition, including a domestic partner or the partner's child(ren).

As of the printing date of this booklet, the Wisconsin tax code has not been updated to match the federal tax exclusion for medical expenses for non-tax-dependent adult children as provided in the Patient Protection and Affordable Care Act (PPACA). Therefore, the ERA plan must follow federal definition of eligible dependent that was in effect prior to the passage of PPACA. This means that you may not submit claims for your non-tax-dependents.

What are the contribution limits?

Minimum annual contribution: $100

Maximum annual contribution: $7,500

Who is a qualified dependent?

Your Medical Expense Reimbursement Account may be used to reimburse eligible expenses incurred by:

- yourself
- your spouse
- your qualifying child or
- your qualifying relative.

An individual is a qualifying child if they are not someone else's qualifying child and:

- are a U.S. citizen, national or a resident of the U.S., Mexico or Canada
- have the following specified family-type relationship to you: son/daughter, stepson/daughter, eligible foster child, legally adopted child or a descendant of any such individual (grand/great grandchild), brother/sister, half-brother/sister, stepbrother/sister or a descendant of such individual (nephew/niece).
- live in your household for more than half of the taxable year
- are less than 19 years old or younger (less than 24 years, if a full-time student) at the end of the taxable year and be younger than the taxpayer claiming such individual, and
- have not provided more than one-half of their own support during the taxable year.

Beginning January 1, 2011, certain OTC drugs and medicines will no longer be eligible for reimbursement without a prescription from your physician.

Be sure to visit www.myFBMC.com for regular updates about OTC eligibility.

An individual is a qualifying relative if they are a U.S. citizen, national or a resident of the U.S., Mexico or Canada and:

- have the following specified family-type relationship to you: son/daughter, stepson/daughter, eligible foster child, legally adopted child or a descendant of any such individual (grand/great grandchild). brother/sister, niece/nephew, half-brother/sister, or stepbrother/sister, parent (or an ancestor of either), stepparent, aunt/uncle, certain in-laws (son-, daughter-, father-, mother-, sister- and brother).
- are not someone else's qualifying child and receive more than one-half of their support from you during the taxable year or
- if no specified family-type relationship to you exists, are a member of and live in your household (without violating local law) for the entire taxable year and receive more than one-half of their support from you during the taxable year.

Note: There is no age requirement for a qualifying child if they are physically and/or mentally incapable of self-care. An eligible child of divorced parents is treated as a dependent of both, so either or both parents can establish a Medical Expense Reimbursement Account.

What expenses are eligible for reimbursement?

To be eligible for reimbursement, IRS regulations require that expenses must be for medical care incurred primarily for the diagnosis, care, mitigation, treatment or prevention of disease or illness and for treatments affecting any part or function of the body. Any expense that is recommended for the improvement of general health is **not** eligible.

Medical Expense Reimbursement Account

Eligible Expenses (partial list)*

- Acupuncture
- Alcoholism treatment
- Ambulance service
- Artificial limbs
- Birth control pills
- Braille books and magazines[3]
- Car controls for the handicapped
- Chiropractic care
- Contact lenses (corrective)
- Contact lens solutions & cleaners
- Crutches
- Dental fees
- Dental implants
- Diagnostic tests
- Doctors' fees
- Duplicate prosthetic devices
- Drug addiction treatment
- Drugs[2]
- Experimental medical treatment
- Eyeglasses
- Guide dogs
- Health and dental insurance deductibles/co-payments
- Hearing aids & exams
- Hearing treatment
- Hospital services
- In-patient or out-patient therapy for mental or nervous disorders
- Injections
- In vitro fertilization
- Lab fees
- Laser eye surgery
- Learning disability tuition[1]
- Massage therapy[1]
- Medical Mileage (See Page 17)
- Nursing services
- Optometrist fees
- Orthodontic treatment
- Over-The-Counter (OTC) medicines[2]
- Orthopedic shoes[3]
- Oxygen
- Psychoanalysis
- Periodontal fees
- Prescription drugs to alleviate nicotine withdrawal symptoms
- Reconstructive surgery after mastectomy[1]
- Smoking cessation programs/ treatments
- Radial keratotomy
- Special schools for the handicapped
- Surgery
- Telephone for the deaf
- Transplants of organs
- Transportation for local and medically necessary out-of-town care (see Page 17)
- Vaccinations
- Vitamins/natural supplements (prescribed)[2]
- Weight-loss programs/ meetings[4]
- Wheelchairs
- X-rays

1. Requires a Letter of Medical Need from the treating healthcare provider (see the next column for more information).

2. Not all prescription or OTC drugs are approved by the IRS as eligible for reimbursement (see Page 16 for more information).

3. Only the increased cost of a special version of an otherwise personal item is reimbursable (see Page 17 for more information).

4 Expenses incurred for weight loss programs and special foods may only be reimbursable if a physician prescribes the treatment as medically necessary to prevent, treat or alleviate a specific, diagnosed medical illness (such as hypertension, diabetes, or obesity). See Page 17 for more information.

* IRS-qualified medical expenses are subject to federal regulatory change at any time during a tax year.

What expenses are ineligible?

- Insurance premiums
- Vision warranties and service contracts
- Health or fitness club membership fees. These fees may be eligible if prescribed to treat a diagnosed medical condition such as diabetes. Written proof of medical necessity is required.
- Cosmetic surgery or expenses primarily for cosmetic purposes
- Expenses for services provided outside the plan year or your period of coverage.

A more complete list appears in IRS Publication 502, available at your Internal Revenue Service office or from the IRS Internet site at **http://www.irs.ustreas.gov/prod/forms_pubs/pubs.html**.

Note: IRS regulations prohibit personal insurance premiums, including long-term care, and any advance payments for future care, such as fees to a retirement facility, from being reimbursed through a Medical Expense Reimbursement Account, even though it is listed as deductible in IRS Publication 502.

When is a Letter of Medical Need required?

Medical care that is provided for specific medical purposes, but may also be provided for personal and/or cosmetic reasons, will require a signed, dated and completed Letter of Medical Need from the attending healthcare professional.

A Letter of Medical Need must accompany the first reimbursement claim each plan year, even if it is for continuing service.

Examples of services that need a Letter of Medical Need include massage therapy, weight-loss programs, and prescriptions for drugs like Accutane, Rogaine and Viagra, that are primarily prescribed for cosmetic reasons.

Note: Budget conservatively. No reimbursement or refund of Medical Expense FSA funds is available for services/surgeries that do not occur.

Medical Expense Reimbursement Account

Who should complete the Letter of Medical Need form?

The Letter of Medical Need should be completed by your healthcare provider (your primary care physician or the healthcare professional who provides the treatment) who will provide the medical diagnosis and treatment on the Letter of Medical Need.

What should be included on the Letter of Medical Need?

The Letter of Medical Need should include the specific diagnosis, the recommended treatment and the duration of the treatment. The healthcare professional must sign and date the Letter of Medical Need. You may use the Letter of Medical Need Form or any other documentation from the provider which includes all of the required information. **A Letter of Medical Need Form is available on the FBMC and ETF websites.**

What if my healthcare needs change after the plan year starts?

The IRS prohibits changes in Medical Expense ERA coverage due to a change in your healthcare plan coverage or eligibility. Likewise, a change in your health plan's drug formulary or the status of over-the-counter (OTC) drugs is not an event that allows for a mid-plan year change. Be sure to verify with your healthcare provider (prior to the commencement of the upcoming plan year) that you are a suitable candidate for any procedure (such as laser eye surgery or other elective procedure) before committing the money to your Medical Expense ERA. Unused funds designated for a medical expense account cannot be refunded to you. IRS-qualified medical expenses are subject to federal regulatory change at anytime during a tax year.

Are expenses related to weight-loss eligible for reimbursement?

The IRS officially recognizes obesity as a disease and out-of-pocket medical expenses for doctor prescribed treatment of obesity **is** reimbursable under your Medical Reimbursement Account. This includes treatment in weight-loss programs and/or meetings; it **excludes** diet foods that are substitutes for normal nutritional requirements.

Weight loss programs and memberships at a gym undertaken for your general health are **not** reimbursable. When submitting a reimbursement claim, be sure to include a Letter of Medical Need that states the condition for which you are being treated. Remember that gym sign up fees, initial fees or enrollment fees are not reimbursable. **Only the monthly fee is reimbursable.**

What medicines and drugs are eligible for reimbursement?

Prescription medicines and drugs must meet the "medical necessity" definition to be reimbursable. For example, daily vitamins, minerals, and other dietary supplements are not usually eligible for reimbursement because they are used to maintain general health. However, if they are prescribed by your healthcare provider to treat a specific condition (i.e. iron tablets for anemia, calcium supplements for osteoporosis), they are reimbursable if accompanied by a Letter of Medical Need from your physician.

Which over-the-counter items are eligible for reimbursement?

The Patient Protection and Affordable Care Act (PPACA) approved by congress and signed into law by the President changes the way some OTC items qualify for medical reimbursement. **Beginning Jan. 1, 2011, certain OTC drugs and medicines will no longer be eligible for reimbursement without a prescription from your attending provider.**

It's important to remember that you can still use your ERA funds for other eligible medical expenses and prescription purchases at pharmacies that are part of the **IIAS Store List** on **www.myFBMC.com**. Unaffected OTC items will still be reimbursable, as well as affected OTC items with a doctor's prescription.

Note: Newly eligible medicines and drugs are **not** considered a valid change in status event that would allow you to change your annual reimbursement account election amount.

Can I be reimbursed for orthodontia?

Orthodontia expenses are reimbursable if the treatment is designed to correct a medical condition such as malocclusion. Orthodontia expenses for treatment designed primarily to improve one's appearance are not reimbursable. Expenses for orthodontic care may be reimbursed in one of the following ways:

- if you pay an initial down payment at the start of treatment, then spread the remaining balance out under a payment plan, you may be reimbursed for the down payment amount at the time that the braces are installed, and for the monthly service amounts paid through the plan year, or

- if you spread the full contract amount out under a payment plan, you may be reimbursed for your monthly service amounts paid through the plan year, or
- if you pay the complete amount due when treatment begins, you may be reimbursed for the full contract amount, but only in the plan year in which the braces are installed.

See Page 28 for information about submitting a reimbursement request.

I need special equipment to accommodate my illness. Is it reimbursable?

If your reimbursement request includes expenses for items or services that can be provided for either a medical purpose or a cosmetic, personal, living and/or family purpose, or involves a capital expenditure, additional substantiation must be submitted with your claim. In addition to a Letter of Medical Need, you may also need to submit a Personal Use Statement or a Capital Expenditure Worksheet.

You must submit a **Personal Use Statement** with your ERA Reimbursement Request and Letter of Medical Need if you are requesting reimbursement for a special version of an item that is ordinarily used for cosmetic, personal, living and/or family purposes. Only the additional amount of expense over the cost of the item in its normal form is eligible for reimbursement. For example, only the part of the cost of Braille books and magazines used by a visually-impaired person that is more than the cost of regular printed editions may be reimbursed.

The cost of home improvements or special equipment installed in your home may be reimbursable as a **capital expenditure** if the main purpose is medical care for you, your spouse, or dependent. A capital expenditure is an item that has a useful life that extends beyond the end of the taxable year (e.g., air conditioner, blood pressure cuff, etc.). The general rules for the reimbursement of a medically necessary capital expenditure, and the extent to which its cost may be eligible for reimbursement are:

- if it's a special version of an otherwise personal item, only the increased cost over the cost of the item in its normal form is eligible.
- if it's an item permanently attached to property, only the cost exceeding the increase in the property value is eligible.
- if there is no personal element and it's not permanently attached to property, it can only be used by the person who medically requires it, and
- if the item is used by others as well, only a prorated amount of the cost is eligible.

Reimbursement requests for a capital expenditure must include a completed **Capital Expenditure Worksheet**, along with the ERA Reimbursement Request form and a Letter of Medical Need. If you are requesting reimbursement for a capital expenditure that is permanently attached to property, you must also submit an **independent third-party appraisal**. If the appraisal shows that attaching the capital expenditure to the property does not increase the value of the property, then the entire cost of the capital expenditure may be reimbursable. If the appraisal shows an increase in the property's value, then only the amount that exceeds the increased property value is eligible for reimbursement.

For more detailed information and forms pertaining to personal use items and capital expenditures, visit the FBMC or ETF websites. You may also obtain more information by sending an e-mail or calling FBMC Customer Care.

Are travel expenses related to my family's health care reimbursable?

Yes, if the service provided is medically necessary for vision, dental or medical care, then travel to and from the healthcare provider to obtain service is reimbursable. Submit travel expenses when you are claiming reimbursement for the provided service.

Mileage

Mileage may be reimbursed at a rate of 16.5 cents per mile (amount per mile reimbursable per IRS as of 1/1/10) for trips to and from your healthcare provider. A visit to your pharmacy will be treated as a visit to your local healthcare provider. **This rate is subject to change by the IRS.**

Parking fees and tolls

You may seek reimbursement for parking fees and tolls to your medical appointment. To substantiate the claim you will need to provide a receipt for the toll and/or parking fee in addition to a bill or receipt from your healthcare provider.

Expenses incurred for out-of-town healthcare services (i.e., airline fare, hotel room and rental car)

You may be reimbursed for the amounts you pay for transportation to another city if the trip is primarily for, and essential to, receiving medical services. You cannot be reimbursed for a trip or vacation taken merely for a change in environment, improvement of morale, or a general improvement of health, even if you make a trip on the advice of a doctor.

Medical Expense Reimbursement Account

Lodging expenses incurred during my dependent's out-of-town hospitalization

You may be reimbursed for the cost of lodging not provided in a hospital or similar institution. The amount you include in medical expenses for lodging cannot be more than $50 per night for each person.

Lodging is reimbursable for a person for whom transportation expenses are a medical expense because that person is traveling with the dependent receiving medical care. For example, if a parent is traveling with a sick child, up to $100 per night can be reimbursed as a medical expense for lodging for both. Meals are **not** included.

What documentation is required for reimbursement of travel expenses?

You may calculate the mileage on the actual bill/receipt for medical care that resulted in your mileage claim. Include:

- round-trip mileage multiplied by 16.5 cents (This rate is subject to change by the IRS.)
- the name of the provider visited.

Example: If your office visit with Dr. Jay on 1/2/11 resulted in a total of 80 miles round-trip, your note should read: 1/2/11—80 miles x 16.5 cents = $13.20 on 1/2/11. Enter $13.20 as the amount requested for reimbursement on your claim form, along with any other expenses associated with your travel (i.e. parking, tolls). **Attach your statement, bill or receipt from your health care provider along with your request in order to validate your visit.**

Should I use a Medical Expense Reimbursement Account or claim my medical expenses on my 1040?

Unless your itemized medical expenses **exceed** 7.5 percent of your or your family's adjusted gross income, you only get a break by claiming them on your IRS Form 1040. You can save taxes by paying for your uninsured, out-of-pocket medical expenses through a tax-free Medical Expense Reimbursement Account.

For instance, if your family's adjusted gross income is $45,000, the IRS would only allow you to deduct itemized expenses that **exceed** $3,375 (7.5 percent of your adjusted gross income). But, if you have $2,000 in eligible medical expenses, the Medical Expense Account saves you $453 in federal income (15 percent) and Social Security taxes (7.65 percent) on these medical expenses. Your savings will be even greater when you include your state income tax.

With a Medical Expense Reimbursement Account, the money you set aside for eligible medical expenses is deducted from your salary before taxes. So it is ALWAYS tax-free, regardless of the amount. By enrolling in a Medical Expense Reimbursement Account, you **guarantee** your savings.

myFBMC Card® Visa® Card

The myFBMC Card® Visa® Card is issued by First Horizon.

The myFBMC Card® is a convenient reimbursement option that allows FBMC to electronically reimburse eligible expenses under your employer's plan and IRS guidelines. Because it is a payment card, when you use the myFBMC Card® to pay for eligible expenses, funds are electronically deducted from your account.

myFBMC Card® advantages

You can use the myFBMC Card® for eligible, non-medicinal over-the-counter (OTC)* and most prescription expenses at drugstores. Other advantages include:

- **instant reimbursements** for health care expenses
- **instant approval of most prescription expenses, as well as some** medical, vision and dental (others require documentation)
- **no out-of-pocket expense** and
- **easy access** to your account funds.

Note: You **cannot** use the myFBMC Card® for non-prescription medicinal OTC, cosmetic dental expenses or eye glass warranties.

Using the myFBMC Card®

For eligible expenses, simply swipe the myFBMC Card® like you would with any other credit card. Whether at your health care provider or at your drugstore, the amount of your eligible expenses will be automatically deducted from your Medical ERA. For prescription purchases the card will only be accepted at IIAS certified merchants. To find out if a pharmacy or drugstore near you accepts the card, please refer to the **IIAS FAQs** at **www.myFBMC.com**.

Two cards will be sent to you in the mail; one for you and one for your spouse or eligible dependent. You should keep your cards to use each plan year until their expiration date. If you prefer not to use the card, you may still submit a paper claim.

Remember, you can go to **www.myFBMC.com** to activate your card, see your account information, check for any outstanding Card transactions and view the eligible OTC category list.

When do I send in documentation for a myFBMC Card® expense?

You must send in documentation for certain myFBMC Card® transactions, such as those that are **not** a known office visit or prescription co-payment (as outlined in your health plan's Schedule of Benefits). You will be notified if you must send in documentation for these transactions. Documentation for a card expense is a statement or bill showing:

- name of the patient
- name of the service provider
- date of service
- type of service (including prescription name) and
- total amount of service.

Note: This documentation must be sent with an ***FBMC Claim Form*** and cannot be processed without it. Like all other FSA documentation, you must keep your myFBMC Card® expense documentation for a minimum of one year, and submit it to FBMC when requested.

If you fail to send in the requested documentation for an myFBMC Card® expense, you will be subject to:

- withholding of payment for an eligible paper claim to offset any outstanding myFBMC Card® transaction
- suspension of your myFBMC Card® privileges
- payback through payroll
- the reporting of any outstanding myFBMC Card® transaction amounts as income on your W-2 at the end of the tax year.

Note: Card transaction disputes must be filed within 60 days of the transaction date.

What happens if I have money left in my account at the end of the plan year?

Any remaining funds from 2010 will remain on your card and will be used first until exhausted — through March 15, 2011, which is the grace period allowed by the IRS. Then, subsequent claims will be debited from your new plan year account balance.

What agreement am I making when I use the myFBMC Card®?

For more information about the myFBMC Card®, see the Cardholder Agreement that accompanies it.

***Note: Beginning January 1, 2011, most OTC drugs and medicines will no longer be eligible for purchase with the myFBMC Card®.**

Visit www.myFBMC.com for more information.

Dependent Care Reimbursement Account

Dependent child, adult and elder care expenses make up a significant portion of many family budgets. The Dependent Care Reimbursement Account lets you use tax-free dollars to cover such expenses – enabling you and your spouse to work, actively look for work or for you to work and your spouse to attend school full time.*

***Note:** Federal tax law does not allow an individual to be covered under a Dependent Care Expense Account unless they are a qualified dependent as described below. Therefore, you cannot be reimbursed for the expenses of anyone who does not meet this definition, including a domestic partner or the partner's child(ren).

What are the contribution limits?

- If you file your income taxes as "head of household" or "married, filing jointly", you can put up to $5,000 a year into your account. **Note:** If you and your spouse establish separate Dependent Care Reimbursement Accounts, the **combined** total may not exceed $5,000.
- If either you or your spouse earn less than $5,000 a year, you can deposit only as much as the **lower** of the two incomes.
- If you are married, but file a separate federal income tax return, you may deposit a maximum of $2,500 to your Dependent Care Reimbursement Account.
- **Note:** If your spouse is a full-time student or incapable of self-care, your maximum is $3,000 a year for one dependent and $5,000 a year for two or more dependents.
- If you have only one eligible child, your maximum for IRS tax credit is $3,000, but you may set aside up to $5,000 through ERA if your tax filing status allows.
- The minimum annual contribution is $100.

Note: The Dependent Care Account is not for medical expenses incurred by dependents.

Who is a qualified dependent?

You may use your Dependent Care Account to receive reimbursement for eligible dependent care expenses for **qualifying individuals**.

A qualifying individual includes a **qualifying child** if they:

- are a U.S. citizen, national or a resident of the U.S., Mexico or Canada
- have a specified family-type relationship to you
- live in your household for more than half of the taxable year
- are 12 years old or younger and
- have not provided more than one-half of their own support during the taxable year.

A qualifying individual includes your **spouse** if they:

- are physically and/or mentally incapable of self-care
- live in your household for more than half of the taxable year and
- spend at least eight hours per day in your home.

A qualifying individual includes your **qualifying relative** if they:

- are a U.S. citizen, national or a resident of the U.S., Mexico or Canada
- are physically and/or mentally incapable of self care
- are not someone else's qualifying child
- live in your household for more than half of the taxable year and
- spend at least eight hours per day in your home and
- receive more than one-half of their support from you during the taxable year.

Note: If you are the tax dependent of another person:

- you cannot claim qualifying individuals for yourself.
- you cannot claim a qualifying individual if they file a joint tax return with their spouse.
- only the custodial parent of divorced or legally-separated parents can be reimbursed using the Dependent Care Account.

What rules apply for dependent care?

- Eligible dependent care expenses must be for the physical care of the dependent, either inside or outside the home.
- Dependent care cannot be provided by you, your spouse or other dependent.
- If you are married, your spouse must work, actively look for work, be a full-time student or be mentally or physically incapable of self-care.

For more information, refer to IRS publication 503 available at your Internal Revenue Service office or from the IRS Internet site at **http://www.irs.ustreas.gov/forms_pubs/pubs.html**.

Dependent Care Reimbursement Account

What expenses are eligible for reimbursement?

- Day and dependent care facility fees for qualified dependents
- Before-school and after-school care for qualified dependents
- Local day camp fees for qualified dependents (Sports camps and other instructional camps are excluded **unless** the primary purpose of the camp is for the physical care of the child.)
- Fees for at-home care of qualified dependents that allow you to work and your spouse to either work, actively look for work, or go to school full time
- Charges for preschool and nursery school may qualify as dependent care expenses, if the attendance allows you to work and your spouse to either work, actively look for work or for you to work and your spouse to attend school full time

What expenses are ineligible?

- Educational expenses incurred for a child in kindergarten or above
- Child support payments, or care for any periods of time that your child or dependent is not living with you
- Health care costs, educational tuition
- Overnight care for your dependents (**unless** it allows you and your spouse to complete shiftwork during that time)
- Nursing home fees
- Books or supplies
- Activity fees
- Deposits, **unless** part of fee is for care of dependent
- Meal and transportation costs, if they are separate from your dependent care expenses
- Expenses incurred outside the plan year or your period of coverage

Should I use a Dependent Care Reimbursement Account or a Child Care Tax Credit?

Generally a Dependent Care Reimbursement Account saves you more in taxes than the Child Care Tax Credit, but it depends on your income.

- If you expect your adjusted gross family income to exceed $24,000, and you are not in the 15 percent tax bracket, the Dependent Care Reimbursement Account will probably benefit you more, but you should consult your personal tax adviser regarding your specific situation.
- You can use the Dependent Care Reimbursement Account and file for a tax credit as long as the total for both (the amount you have placed in your account plus the amount you have paid for dependent care) does not exceed the tax credit limits; $3,000 for one dependent and $6,000 for two or more dependents.
- You cannot use the tax credit if you are married and filing separately.
- You cannot use the same expenses for both the tax credit and your Dependent Care Reimbursement Account.
- Carefully follow IRS reporting requirements for Dependent Care accounts. IRS Form 2441 (1040) and Schedule 2 (1040A) require that you provide the name and tax identification number (or Social Security number) of the dependent care provider when filing your taxes.

Dependent Care Reimbursement Account

Here's how one family saved

Thousands of dollars in day care expenses for their children made Mike and Kathy Mallory decide to set up a tax-free Dependent Care Reimbursement Account.

Last year, they paid $6,000 for day care for their three-year-old twin daughters. The Mallorys realized they would benefit by having the tax-free deductions taken from their salary. The maximum contribution to a Dependent Care Reimbursement Account is $5,000. They decided to put the maximum $5,000 in the reimbursement account and pay the rest of the cost out-of-pocket.

Reimbursement from their tax-free reimbursement account for their day care expenses during the plan year will save them about $500 more in taxes than if the Mallorys used the dependent care income tax credit.

Should the Mallorys use a Dependent Care Reimbursement Account? YES

Personal Information

Names: Mike and Kathy Mallory

Ages: Mike, 32; Kathy, 31

Family Status: Married, two children

Health: Excellent

Other information: The Mallorys paid a large amount in taxes last year; they are anxious to reduce their taxes and start renovations to their home.

Employment: Both state employees for eight years

Income: Mike $33,000
Kathy $35,000

	WITH TAX DEDUCTION	WITH ERA
1. Taxable Income Before Reimbursement**	$42,000.00	$42,000.00
2. Less: Dependent Care Paid Before Tax	0.00	–5,000.00
3. Taxable Income After Reimbursement	$42,000.00	$37,000.00
4. Less: Federal taxes† (applied to line 3)	-5,462.50	–4,712.50
5. Less: State Income taxes***	-2,428.02	–2,067.49
6. Less FICA taxes (7.65% of line 3)	-3,213.00	–2,830.50
7. Less: Dependent Care Paid After Taxes	-6,000.00	–1,000.00*
8. Plus: Dependent Care Income Tax Credit	+1,200.00	+200.00
9. Income After Dependent Care Expenses	$26,096.48	$26,589.51
10. Additional Taxes Saved With Account (Individual tax rates may vary.)		**$493.03**

* The Mallorys can also claim the extra $1,000 in child care expenses as an income tax credit.

** Standard deductions and exemptions have been deducted from the adjusted gross income to arrive at this taxable income amount.

***Individual state tax rates will vary. Wisconsin State tax information may be found at the Department of Revenue Internet site, **http://www.dor.state.wi.us**. State income taxes calculated by applying 4.6% to first $13,420 and 6.15% to income between $13,420 and 26,850 and 6.5% on the remainder.

† Federal taxes calculated by applying a 10% tax to the first $16,750 of income and a 15% tax on the remaining amount.

Note: No earned income credits included in calculations.

Impact of the ERA Program on Other Benefits

Social Security

Participation in the ERA program, including the Premium Conversion component, will reduce salary used for calculating your eventual Social Security benefit. However, the benefit reduction is small compared with the tax savings earned. The following table compares the possible lifetime Social Security reduction with tax savings realized through the ERA program.

Number of years using tax-free premiums	Estimated reduction in Total Lifetime Social Security benefits		Total tax savings*
	MALE	FEMALE	
10	$1,536	$1,865	$2,718
20	3,071	3,729	5,436
30	4,608	5,596	8,154
35 or more	5,376	6,528	9,513

* Tax savings based on a 15% federal income tax and 7.65% Social Security tax, with $100 in tax-free contributions per month. Your savings will be even greater when you include your state income tax. Higher tax brackets will also increase tax savings; Social Security reduction remains the same. Assumes retirement at age 65. The difference in male and female estimates is based on life expectancy at retirement.

Wisconsin Retirement System (WRS) and other state benefits

State law (Wis. Stats. §40.87) specifically states that participation in the ERA program will **not** reduce your wages for calculating state retirement benefits.

ERA reductions will **not** reduce your gross income for the purpose of calculating any other state benefits such as sick leave conversion credits, income continuation insurance, life insurance, unemployment or Workers' Compensation.

Tax-sheltered annuities and deferred compensation

Participation in the ERA program does **not** affect your participation in a tax-sheltered annuity or deferred compensation program.

Changes During the Year

Am I permitted to make mid-plan year election changes?

You may enroll, terminate or change your ERA election mid-plan year only if you have experienced a qualified Change in Status event as provided by IRS regulations and the Wisconsin ERA program.

The desired election change must correspond to, and be consistent with, the event. Experiencing a Change in Status event will not automatically permit a mid-plan year election change unless applicable IRS consistency rules are also met. A mid-plan year election change can only be made on a future basis.

What is the deadline for filing a Change in Status request?

A properly completed Change in Status Request Form must be received by FBMC's Wisconsin Office within 30 days after a qualifying event as described in the following section, "What changes are permitted by the IRS?"

What is my coverage effective date if my Change in Status request is approved?

Your election change or enrollment will be effective on the first of the month on or after the date your approved Change in Status Form is received by FBMC's Wisconsin office. Forms will be date-stamped when received and the first changed deduction will be taken from the first available paycheck. **In no instance will the enrollment or change in coverage be effective before the first of the month following the date of the qualifying event.**

What is my period of coverage when I make an election change?

A mid-plan year election change will result in split periods of coverage. Money from a previous period of coverage can be combined with amounts after a permitted mid-plan year election change and can be used through the end of the plan year. However, expenses incurred before the permitted election change can be reimbursed only up to the annual election amount that was in effect prior to the change. (See above for information about the effective date of a change in status request).

Examples: During the annual enrollment period, Ms. Stevens elects to contribute $300 to her Medical Expense ERA. She incurred $300 of eligible expenses in February and was reimbursed for the full amount. Ms. Stevens was married in May. This change in status event allows her to increase her account because of the added expense of her spouse. She elected to increase her annual Medical Expense ERA by $300. The effective date of this change is June 1. Ms. Stevens now has an additional $300 that can be used for expenses for either her or her husband that occur on or after June 1.

Mr. Smith elected to contribute $400 to his Medical Expense ERA during open enrollment. He incurred $500 of eligible medical expenses in May, but did not request reimbursement for these expenses. In June, Mr. Smith's wife has a baby. Because he realizes his medical expenses will increase, he increases his annual election amount by $200. The effective date of this change is July 1. Mr. Smith now has $600 available in his Medical Expense ERA. In August, he requests reimbursement for the $500 of expenses he incurred in May and $100 of expenses incurred in July. Mr. Smith will be reimbursed only $400 for the May expenses because his annual election amount was $400 when these costs were incurred. He will be reimbursed for the $100 of July expenses, leaving a balance of $100 for the remainder of the plan year.

Mr. Johnson elected to contribute $800 to his Medical Expense ERA during open enrollment. He was reimbursed $400 for eligible expenses incurred in July. He was married in August and elected to increase his annual election amount by $300. His change is effective September 1. He now has up to $400 (the balance of his original election amount) available for expenses incurred prior to September or $700 (the $400 balance plus the additional $300) that may be used for expenses incurred on or after September 1.

Ms. Jones elected to contribute $600 to her Medical Expense ERA during open enrollment. She was reimbursed for the entire $600 for eligible expenses that were incurred in February. Ms. Jones' daughter gets married in May, thus Ms. Jones loses an eligible dependent. Ms. Jones submits a change in status request to decrease her annual amount. Because Ms. Jones has already incurred and was reimbursed for eligible expenses, she may not reduce her annual amount, even though she lost a dependent.

Changes During the Year

How do I request an election change?

Step 1 – Review the Change in Status rules in this section. If you have any questions about the eligibility of a requested change or completing the form, contact FBMC's Wisconsin office **(608) 592-2020** or **rseverson@fbmc.com**.

Step 2 – Obtain a Change in Status Request Form from your Payroll/Benefits Office, from ETF's Internet site, or from FBMC's Wisconsin office.

Step 3 – Determine the amount that you wish to contribute for the remainder of the plan year following your effective date of coverage. Your department's Payroll/Benefits Office will assist you in determining the number of paychecks remaining in the year.

Step 4 – Complete, sign and date the form and submit it to FBMC's Wisconsin office: **FBMC, 113 S. Main Street, Suite 200, Lodi, WI 53555 or fax (608) 592-2030**. Retain a copy of documentation supporting your mid-plan year election change request. (It does not need to be submitted with your request.) Examples of documentation are: marriage licenses, divorce decrees, birth certificates, etc.

Step 5 – FBMC's Wisconsin office will review, on a uniform and consistent basis, the facts and circumstances of each properly completed and timely Change in Status Request Form. If the requested change is approved, a copy of the form will be forwarded to your Payroll/Benefits Office and to FBMC's Florida office. If your ERA election change request is denied, you will have 30 days from the date of the denial to file an appeal with FBMC by following the procedures in the "Appeal Process" section appearing on Page 7.

Note: Be sure to send your form to FBMC's Wisconsin office in a timely manner. If your form is received after the first of the month, your coverage will not start until the first of the following month.

Changes During the Year

What changes are permitted by the IRS?

Legal Marital Status: (Marriage; death of spouse; divorce; legal separation; and annulment)	**Medical Expense Account** • If you marry, you may increase your election when a family member is added; or cease or decrease your election if: (i) you, your spouse or dependents become eligible under your new spouse's employer's medical expense account plan; and (ii) your spouse is a participant in his or her employer's plan, and (iii) coverage for the affected individual becomes effective or is increased under the other employer's plan. • If you cease to be married, you may decrease your election for the former spouse who loses eligibility. You may enroll in or increase your own election only if you have lost coverage under your former spouse's medical expense plan. **Dependent Care Account** • If you marry, you may enroll in or increase your election to accommodate any newly-acquired dependent(s); or decrease or cease coverage if your new spouse is not employed or makes a dependent care reimbursement account coverage election through his or her employer. • If you cease to be married, you may enroll in or increase your election to accommodate your newly-eligible dependent (e.g., due to divorce from non-working spouse); or decrease or cease coverage if eligibility is lost due to an event (e.g., because your dependent now resides with ex-spouse).
Number of Your Tax Dependents (Birth; death; adoption; and placement for adoption)	**Medical Expense Account** • If you gain a dependent, you may enroll in or increase your election for the newly-acquired dependent. • If you lose a dependent, you may decrease or cease your election for the dependent who loses eligibility. **Dependent Care Account** Same as Medical Expense Reimbursement Account.
Change In Status of Employment that Affects Eligibility of the employee, the employee's spouse, or the employee's dependent: (Termination or commencement of employment; strike or lockout; commencement of or return from an unpaid leave of absence; and change in worksite)	**Medical Expense Account** • If you go on an unpaid leave of absence, you may change your election amount, or terminate coverage. • If you return from unpaid leave of absence, you may start an account or change your election amount. • If your spouse terminates employment, or goes on an unpaid leave of absence, you may enroll in or increase your election if your spouse or dependent loses eligibility for participation in their employer's medical reimbursement plan. • If your spouse or dependent commences employment or returns from an unpaid leave that triggers a gain in eligibility under his or her employer's plan, you may not drop your Medical Reimbursement Account coverage but you may decrease your election if your spouse or dependent gains eligibility and enrolls in his or her employer's medical reimbursement plan. **Dependent Care Account** • If you terminate employment, your salary reductions cease but you may continue to request reimbursement for eligible expenses from your account until you exhaust your account balance or the plan year ends even if you have not contributed the full annual amount for which you enrolled. You cannot claim expenses that are incurred while you are not working. • If you return from unpaid leave, you may start an account or change your election amount. • If your spouse terminates employment, or goes on an unpaid leave of absence, you may cease participation if your spouse's loss of employment renders your dependent ineligible for this benefit. • If your spouse starts employment or returns from unpaid leave, you may start an account or increase your election amount to reflect the new eligibility of your dependent (if your spouse previously did not work). You may also terminate your account if your dependent is added to a dependent care plan offered by your spouse's employer.
Dependent satisfies or ceases to satisfy eligibility requirements. (Gain or loss of dependent status as defined by IRC Section 152)	**Medical Expense Account** • If your dependent gains eligibility, you may enroll in or increase your election to take into account the expenses of the affected dependent. • If your dependent ceases to be eligible you may not drop your coverage but you may decrease your election to take into account the ineligibility of the expenses of the affected dependent. **Dependent Care Account** • If your dependent gains eligibility, you may enroll in or increase your election to take into account expenses of affected dependent. • If your dependent ceases to satisfy eligibility requirements (e.g., attains age 13) you may decrease or terminate your election to take into account the expenses only of the affected dependent.

Changes During the Year

Change in Place of Residence (Your Own, Your Spouse or Dependent) (Does not apply to Medical Expense Accounts)	**Dependent Care Account** You may make an election change if a change in place of residence results in a change in the cost or coverage of your dependent care provider.
Open Enrollment Under Other Employer's Plan (Does not apply to Medical Expense Accounts)	**Dependent Care Account** You may make an election change when your spouse or dependent makes an open enrollment change in coverage under their employer's plan if: their employer's plan year is different from your employer's cafeteria plan, their employer's plan permits a mid-plan year election change under this event, and they participate in a dependent care reimbursement account.
Significant Coverage Curtailment (Does not apply to Medical Expense Accounts)	**Dependent Care Account** If your dependent care provider significantly reduces its available hours, or goes out of business, you may revoke your election and make a new election for coverage with another dependent care provider. You may also make a corresponding election change when you switch dependent care providers. For example, if you send your child to a daycare center, you can switch to another daycare center or provider. If switching dependent care providers results in a cost increase or decrease, you can make a corresponding change to your dependent care election.
Cost Increase or Decrease (Does not apply to Medical Expense Accounts)	**Dependent Care Account** If the cost charged by your dependent care provider increases or decreases, you may change your elected contribution under the plan. However, if the day care provider is related by blood or marriage, you cannot change your election amount solely on a desire to increase or decrease the amount being paid to that relative.
Certain Judgments, Decrees, or Court Orders (Does not apply to Dependent Care Accounts)	**Medical Expense Account** If a judgment, decree, or court order from a divorce, legal separation, annulment, or change in legal custody requires that accident or health coverage for your dependent child (including a dependent foster child) be provided by: • you may change your medical reimbursement account election to provide the child with corresponding coverage. • your spouse, former spouse, or other individual, you may change your medical reimbursement account election to cancel corresponding coverage for the child if the other individual actually provides the coverage.
Eligibility for Medicare and Medicaid (Does not apply to Dependent Care Accounts)	**Medical Expense Account** If you, your spouse, or your dependent – • are enrolled in your employer's health or accident benefit plan, and become entitled to and enroll in Medicare or Medicaid (other than coverage solely for pediatric vaccines), then for that individual you may decrease your medical reimbursement account election, if the Medicare/Medicaid coverage is more comprehensive, or increase it if prior employer coverage was more comprehensive. • lose eligibility for Medicare or Medicaid, then for that individual you may increase your election; or decrease it where the employer plan is more comprehensive.

Reimbursement Information

How do I get my money?

If you utilize the myFBMC Card® for eligible medical expenses, the funds are automatically deducted from your Medical ERA.

However, if you pay out-of-pocket for an eligible medical or dependent care expense, simply submit a claim to FBMC as explained below. You do not have to pay for the services before submitting a request for reimbursement, but you must actually receive the service before you can be reimbursed.

Important – If you have money left in your account(s) at the end of 2011, you may use it for reimbursement of expenses incurred through March 15, 2012. However, reimbursement of claims will be made strictly on a "first-in, first-out" basis. This means that if you have 2011 expenses that you intend to have paid from your 2011 contributions, they must be submitted and processed **before** you submit any 2012 reimbursement claims to assure that they are paid out of your 2011 balance.

Step 1

Complete, sign and date an ERA Reimbursement Request Form, available from the FBMC or ETF Internet sites, or by calling FBMC at 1-800-342-8017.

Step 2

Attach legible documentation to support your reimbursement claim. Acceptable documentation includes a copy of a statement, bill, or receipt **(no cancelled checks or charge receipts)** from your provider.

Dependent care claim – your statement, bill, or receipt must include:

- the name and address of the provider/facility,
- the provider's SSN or Tax ID Number
- the beginning and ending dates of the provided services,
- the cost of the services, and
- the age, grade and name of the qualifying individuals for whom service was provided.

Note: Separate receipts are not required if your dependent care provider signs your Reimbursement Request Form after you have completed and signed it.

Medical expense claim – your statement, bill, invoice or Explanation of Benefits (EOB) from your insurance company must include:

- The name of the provider
- The date service(s) were received
- The cost of the service(s)
- The type of medical service(s) provided,
- The name of the person(s) for whom the service(s) were provided,
- The complete name of the drug (and Rx number, if a prescription drug) or medical supply.

If the claim is for treatment that may be deemed to be cosmetic or for general health purposes, also attach a Letter of Medical Need. (See Page 15 for more information about a Letter of Medical Need.) Proof of medical need must be submitted once annually for care that will continue throughout the plan year. If care continues into the next plan year, be sure to include the Letter of Medical Need with the first claim for care in the subsequent plan year.

If the claim is for a capital expenditure, attach documentation to substantiate your expense as a medically necessary item. See Page 17 for more information.

If the claim is for orthodontia, include a copy of the patient's contract for the treatment with the first claim in each plan year (unless the full expense is claimed in the plan year in which the braces are first installed). If you are on a payment schedule, include a statement or payment coupon that shows the month for which you're requesting reimbursement.

Step 3

Mail or fax the white copy of the Reimbursement Request Form, along with the required documentation, to:

Fringe Benefits Management Company (FBMC)
Post Office Box 1800
Tallahassee, FL 32302-1800

Fax: 1-888-326-2658

If you fax your request, you do not need to mail a copy of the request to FBMC. Be sure to include a separate cover page with your name and total number of pages (including cover page) and keep a record of the fax number from which you sent and the date it was sent.

Step 4

FBMC will process your request within five business days from the day it receives a properly completed Reimbursement Request Form and all the required documentation.

Reimbursement Information

When can I submit claims?

- Eligible expenses cannot be reimbursed until **after** the service has been rendered.
- You may submit requests as often as you wish, as long as the date of service for which you are requesting reimbursement has passed.

Claim Tips

- You can receive your reimbursement faster by enrolling in the Rapid Refund option described below.
- To check on the status of your ERA account(s) at anytime, call the Interactive Benefits Information Line at 1-800-865-FBMC (3262) or visit FBMC's website to access your FBMC account information (See Page 8 for details).
- You must contact FBMC Customer Care directly to submit a change of address. Simply filling out a reimbursement form with your new address information does not guarantee that your reimbursement will be sent to your new address.

What is the deadline for submitting claims?

The deadline for submitting claims for services provided in the 2011 Plan Year, including the grace period, is April 15, 2012. All medical expense and dependent care claims must be received by FBMC or postmarked by this date to be reimbursed from 2011 funds.

How can I get my money faster?

Use Rapid Refund!

- Enrolling in Rapid Refund will allow your reimbursement claim check to be deposited directly into your checking or savings account.
- To take advantage of this option, call FBMC at 1-800-342-8017 and request a Rapid Refund enrollment form. You may also obtain a Rapid Refund form at the FBMC or ETF Internet sites.

Initial set up for Rapid Refund may take four to six weeks. You may enroll in Rapid Refund at any time during the plan year. If you currently participate in Rapid Refund, you do not need to file another form for the new plan year. However, if you wish to cancel Rapid Refund, or if you change bank accounts, you must complete and submit a new form.

How can I find out my account balance?

There are two ways that you can access your ERA account to check on a claim, verify the status of an account, request a form and more!

Phone: The Interactive Benefits Information Line is FBMC's 24-hour automated phone system. Simply dial 1-800-865-FBMC (3262). The system will give you a list of options and guide you through a simple, step-by-step process to obtain the information you need.

Internet: Interactive Benefits are available online at **www.myFBMC.com**. You can also access your account information through ETF's website. Go to **http://etf.wi.gov** and click on the "Members" tab at the top of the page. Select "Employee Reimbursement Accounts (ERA)" from the menu, then click on "Fringe Benefits Management Company" to take you to FBMC's website.

Personal Account Information

Please see Page 8 for important information regarding your User ID and password.

Worksheets

When you use your myFBMC Card®, many of your medical expenses may be paid for electronically. At your request, your ERA reimbursement checks may be deposited into your checking or savings account by enrolling in "Rapid Refund." Rapid refund enrollment forms are available on the ETF internet site, or call FBMC Customer Care. Application processing may take four to six weeks.

Be sure to consult your *It's Your Choice* health plan enrollment book and/or your other insurance benefit information to determine your new co-payments, deductibles and covered benefits for the 2011 Plan Year.

Tax-Free Medical Expense Reimbursement Account

PROJECTED PLAN YEAR EXPENSES (NOT covered by insurance)

1. Eligible Medical Expenses to be incurred from January 1, 2011 through December 31, 2011**

Insurance deductibles, co-payments (insurance premiums are not reimbursable)	$ _____
Immunizations, injections and vaccinations	$ _____
Routine examinations and physicals	$ _____
Dental and orthodontic expenses (non-cosmetic)	$ _____
Prescription drugs or co-payment amount	$ _____
Eyeglasses and contacts (corrective, including cleaning/wetting solutions, etc.)	$ _____
Transportation to and from medical provider	$ _____
Medically necessary nursing home care	$ _____
Medically necessary surgery*	$ _____
Other expenses	$ _____

2. Total annual dollar amount $ _____

$7,500 MAXIMUM

3. Divide by the number of regular paychecks you will receive during the plan year. ÷ _____

4. Reduction per regular paycheck $ _____

Tax-Free Dependent Care Expense Reimbursement Account

1. Eligible Dependent Care Expenses to be incurred from January 1, 2011 through December 31, 2011**

Infant/toddler	$ _____
Preschool	$ _____
Before-school or after-school care	$ _____
Reporting days (child in school only half a day)	$ _____
School holidays/vacations/in-service	$ _____
Adult, elder and other dependent care	$ _____

2. Total annual dollar amount $ _____

Remember, your total family contribution cannot exceed IRS limits for the plan year.

3. Divide by the number of regular paychecks you will receive during the plan year. _____

4. Reduction per regular paycheck $ _____

Note: Take into consideration the possibility of turnaround delays in receiving reimbursement checks when determining how much you can afford to contribute to either Reimbursement Account.

* Unused funds designated for reimbursement accounts cannot be refunded to you. Please verify with your healthcare provider (prior to the commencement of the upcoming plan year) that you are a suitable candidate for any surgical procedure before committing the money to your ERA.

** Expenses incurred through March 15, 2012, may be reimbursed using 2011 contributions. However, plan conservatively to reduce the risk of forfeiting money.

This document provides a description of available benefits for easy reference purposes. Official plan documents are available for inspection at the:
Department of Employee Trust Funds
P.O. Box 7931
Madison, WI 53707-7931

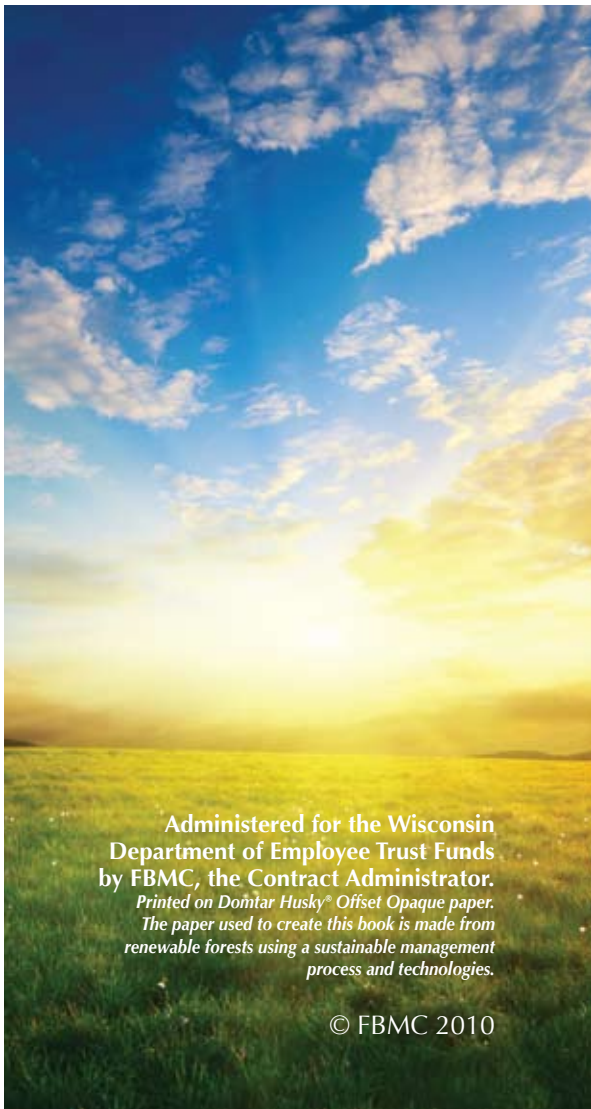
etf
WISCONSIN DEPARTMENT OF EMPLOYEE TRUST FUNDS

FBMC
Premier Benefits Solutions

Contract Administrator
Fringe Benefits Management Company
P.O. Box 1878 • Tallahassee, Florida 32302-1878
Customer Care 1-800-342-8017 • 1-800-955-8771 (TDD)
www.myFBMC.com

Information contained herein does not constitute an insurance certificate or policy. Certificates will be provided to participants following the start of the plan year, if applicable.

FBMC/WISC/0910



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